Massachusetts Department of Public Health
Early Intervention
Family Fee Exemption Request Form

Date: _____/_____/_____ Early Intervention Program: _____

SECTION A: IDENTIFYING INFORMATION

Child's Legal Name: _____ Child's Date of Birth: _____/_____/_____

Parent/Guardian's Name(s): _____ Phone: (_____)_____

Parent/Guardian's Address: _____

SECTION B: EXTRAORDINARY EXPENSES WORKSHEET

You *must provide* documentation with this form for out-of-pocket medical expenses incurred for the child and/or other family members or losses due to disaster (e.g. fire, flood, tornado, etc) **during the past twelve months**. Your total expenses must be equal to or greater than 15% of your gross family income to qualify for an exemption. Please complete a Family Fee Exemption Request Form for each child if more than one child is enrolled in Early Intervention.

Expense Category	Expense Amount
Hospital, physician, ambulance (co-pays, deductibles, expenses not covered by insurance)	
Prescription and over-the-counter medications	
Materials, supplies, modifications related to disability	
Specialized Equipment	
Special Food Supplements	
Dental Care	
Mental Health treatment (not covered by insurance)	
Therapies (outside of EI)	
Home Health Care provided by licensed Home Health agency	
Transportation /parking related to disability	
Travel and Lodging related to treatment	
Home Modifications related to disability	
Extraordinary expenses due to disaster (e.g. flood, fire, etc)	
TOTAL ANNUAL EXPENSES	**$**

SECTION C: INCOME DOCUMENTATION

You *must provide* copies of one of the following to substantiate your annual family income:

- Most recent tax return
- Most recent W2(s) and/or 1099(s)
- Last two (2) consecutive pay stubs/advices
- If none of the above is available, a written statement of salary or wages, documenting the amount and periodicity of payment (e.g. weekly, monthly) from the employer will be permissible. The statement must include company/employer name, address, phone number and supervisor/human resource staff signature.

I hereby affirm, under the pains and penalties of perjury, that the information provided is accurate and complete, to the best of my knowledge.

Parent/Guardian's Signature: _____ **Date:** _____

Please send the completed, signed form with copies of all required documentation to Alanna Sheils at 250 Washington Street, 5th Floor, Boston, MA 02108 or fax to (617) 624-5927. The Department will notify the program in writing once a determination has been made, typically within 10 calendar days of receipt.